

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005729	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/19/2012
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00115273.</p> <p>Complaint IN00115273- Unsubstantiated due to lack of evidence.</p> <p>Survey date: September 19, 2012</p> <p>Facility number: 005729 Provider number: 005729 AIM number: N/A</p> <p>Survey team: Connie Landman, RN-TC Diana Zgonc, RN</p> <p>Census bed type: Residential: 56 Total: 56</p> <p>Census payor type: Other: 56 Total: 56</p> <p>Sample: 3</p> <p>Crownpointe of Indianapolis was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00115273.</p> <p>Quality review completed on September 20, 2012 by Bev Faulkner, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1